Iowa Department of Human Services
Bureau of Long Term Care
Bureau of Managed Care/Clinical Services
RFI 2427
October 14, 2002 PEC meeting follow-up

1. **Medicaid trend information – what are the total $$, eligibles, trends for the past five years?**
   Please see attached spreadsheets titled: "Medical Assistance Reversion History FY 1993 through FY 2001 (State General Fund Dollars in Millions)" and "DHS – Medical Assistance Monthly Title XIX Expenditures in State Dollars and Monthly Number of Title XIX Eligibles (Does Not Include Medicaid Program Eligibles Funded by Title TXXI) SFY 1998-2002".

2. **What is the financial impact of the Medicaid waivers on Medicaid (additional costs or cost savings, cost avoidance)?**

   - The federal Centers for Medicare and Medicaid Services require the service cost through Home and Community Based Waivers be no more than the service cost in an institutional setting.
   - The following compares Home and Community Based Waiver costs to institutional costs.

Waiver	Avg. Monthly Waiver cost per Recipient	Avg. Monthly Institutional Cost per Recipient
AIDs/HIV	$ 968.00	$ 3,110.00
Brain Injury	$1,372.00	$ 2,890.00
Elderly	$ 409.00	$ 1,210.00
Ill & Handicapped	$ 757.00	$ 2,250.00
Mental Retardation	$1,967.00	$ 6,610.00
Physical Disability	$ 519.00	$ 1,380.00

3. **What is our procedure for "spot checking" resources of Medicaid recipients? (Report from Department of Labor/Workforce Development). What percentage? How often? How much? What do we find?**
   When a person age 21 or older applies for Medicaid, the Department of Human Services is required to verify all resources reported by the applicant. The local office obtains a release from the applicant allowing the worker to communicate with the appropriate financial institution(s). Resources may also be re-verified at a recipient's annual review. While there is no procedure in place for "spot checking" (randomly checking) resources, if it comes to the Department's attention that a recipient may have additional resources, the worker must request verification. If the verification is returned, the worker determines whether or not the recipient remains eligible. Failure to supply requested information would result in the cancellation of a person's benefits.

4. What number of Medicaid cases are sent to DIA for fraud recoupment per year?

There were several cases for which the fiscal agent issued recovery proceedings in SFY 2001 and 2002. The dollar amounts recovered are as follows:

SFY 2001 95 cases	$284.303.22 disputed	$265,938.81 recovered
SFY 2002 169 cases	$322,710.65 disputed	$251,917.23 recovered

5. What investment is necessary to implement a pre-admission screening for Nursing Facilities? What would be the anticipated cost savings? Timeline?

An interagency team will need to be formed to develop a workplan which would include who would do the pre-admission screening, when the pre-admission screening would be done, how much the screening would cost and what, if any, cost savings could be projected. The interagency team should include the Department of Human Services and the Department of Elder Affairs.

6. What percentage of individuals in nursing facilities are paid through Medicaid?

On average, nearly 56% of all nursing facility residents are paid through Medicaid. On admission to the facility, approximately 64% of nursing facility residents are paid through Medicare, 11% through Medicaid, and 25% from other sources.

7. What is the number of NF beds converted to assisted living beds? How many are occupied by Medicaid recipients?

There will be 224 nursing facility beds de-licensed and 192 assisted living beds will be developed. All of the assisted living units are to be affordable, and 40% or 77 beds are to be occupied by Medicaid recipients, subject to demand. The majority of the nursing facilities that received grants are currently in the process of completing their remodeling, seven of the agencies have completed construction.

8. **How many NF beds are there in the state?**
There are a total of 33,667 NF beds. This includes a combination of Medicare certified, Medicaid certified and comprehensive care beds.

How many are currently empty?
Approximately 14.3%, or 4,811 beds are empty.

How many of those beds are eligible for Medicaid payment?
Approximately 84%, or 4,041 beds are eligible for Medicaid.

Minimum Occupancy Standard
Medicaid currently imposes a minimum occupancy standard when computing a facility's per day rate. The occupancy standard applies to the non-direct care component of the rate. No minimum standard is applied to the direct care component.

The current occupancy standard is set at 80% and is scheduled to be increased to 85% beginning July 1, 2003. For nursing facilities that have occupancy below the standard,

their per day rate for non-direct care is calculated using resident days that are equal to their facility's total licensed capacity multiplied by 80% (current standard). In this way, Medicaid limits reimbursement for inefficient operations (over supply of beds) that have occupancy below the minimum occupancy standard.

Since the average statewide occupancy is approximately 86%, Medicaid's current 80% standard permits many facilities to receive higher reimbursement rates than they would if the statewide occupancy was applied. Since a number of facilities have occupancy rates in the mid to upper 90% range, demonstrating that a higher occupancy rate than 86% is attainable, Medicaid may also be reimbursing for a greater number of empty beds than is economic and efficient.

Bed Hold

The Iowa Medicaid program currently pays nursing facilities to "hold beds" for residents who temporarily leave the facility for a brief hospitalization or for therapeutic reasons such as to visit family and friends. A policy reason for making this type of payment to the nursing facility is to ensure that the resident can return to the same facility and bedroom. If a facility has a waiting list or can otherwise fill the bed with another paying resident, some incentive is likely needed for the facility to "hold the bed" and ensure that the resident can return to the facility. Currently, annual reimbursement for bed hold is approximately $1.4 million (state only $).

However, if a nursing facility has an over supply of beds, it is less likely that the facility will fill all empty beds such that the resident cannot return to the same facility and bedroom from a hospitalization or visit. For this reason, the DHS is considering changing the policy to only pay for "bed hold" when the occupancy of the facility is high.

9. **What is the cost per year of implementing the case mix reimbursement for NFs (hold harmless)?**

Based on the October 1, 2002 rates, the estimated annual fiscal impact of the Hold Harmless rates is approximately $4.2 million state ($11.5 million state and federal); $3.7 million for the freestanding nursing facilities and $.6 million for the hospital based Medicare-certified facilities.

What is the cost for extending the hold harmless past the current fiscal year when we are scheduled to reach full implementation?

Based on the October 1, 2002 rates the estimated annual fiscal impact of extending the hold harmless provision past full implementation of case mix (no more phase-in) is approximately $4.7 million state ($12.8 million state and federal); $4.6 million for the freestanding nursing facilities and $.2 million for the hospital based Medicare-certified facilities.

In a 1998 study it was determined that Iowa has the fifth oldest in the nation with 15.1% of the population over the age of 65. We have the highest percentage of people over the age of 85 in the nation. We have one of the highest rates of nursing facility utilization in the country with 6.8 beds per 1000. (Nationally the average is 4.5 beds per 1000) We have the lowest acuity for nursing facility residents in the country.

10. **What is the utilization rate of generic drugs by Medicaid recipients?**

For the period of 6/10/01 – 5/31/02, generic use was 51.4% of the drug claims.

What are our current co-pays and strategies to incentivize utilization of generics?

The current co-pay is $1.00 (unless less than 21 years of age, pregnant, institutionalized, or for family planning supplies) for a new prescription or refill, regardless of whether it is brand or generic.

Pharmacies are required to dispense the least costly item in stock that meets the order of the physician or other practitioner.

Use of generics is required for products on the Federal Upper Limit (FUL) list and will also be required for the products on the State Maximum Allowable cost list (SMAC). The provider is reimbursed only the generic price for these products unless prior authorization is obtained.

Under what circumstances are brand name prescriptions used?

Brand name products are used when there is no generic available; if it is an exception to the FUL list due to narrow therapeutic index concerns (currently there are 3 drugs exempted- TheoDur, Coumadin and Tegretol) or if a prior authorization is obtained. Prior authorization for Selected Brand Name Drugs is required for selected brand name drugs for which there is available an "A" rated bioequivalent generic product (i.e. drugs contained on the FUL and SMAC lists). For prior authorization to be considered, evidence of treatment failure with the bioequivalent generic drug must be provided. This is transmitted by the physician completing the MedWatch form and faxing this to the federal FDA and the fiscal agent, who will evaluate the failure and determine prior approval/denial.